Indiana Department of Insurance
Filing Company Checklist
BLANKET Accident & Health Policy Review Standards

(Checklist must be submitted with filing—attach as PDF document if filing electronically)

Company Name_____ **NAIC #** _____

Form number(s)_____ **Filing date**_____

Product Type (Some types may be exempt from certain filing requirements as marked by **)
Check all that apply.
☐ Major Medical ☐ Accident Only ☐ Dental ☐ Vision ☐ Disability Income
☐ Specified Disease ☐ Short Term Medical ☐ Indemnity Only ☐ Supplemental Plan
☐ Employer Coverage for Medicare Eligible Only ☐ Other _____

Statute/Regulation	*Requirement*	*N/A*	*Location in submitted documents*	*For IDOI USE ONLY Yes/No/Comments*
General Filing Requirements				
IC 27-1-3-15	***Filing Fee***—We will bill you quarterly for **each** form contained in the filing and for **each** company the form is filed for. The per form fee is $35 or the retaliatory fee based on your state of domicile. **PLEASE DO NOT** submit any filing fees with your filing.			
Bulletin 125	NAIC Standard A&H Transmittal Sheet— Use coding from NAIC Uniform Product Coding Matrix—Links to these items on the IDOI website or www.naic.org			
IC 27-1-26	Flesch readability certification			
Bulletin 125	A cover letter (ONLY if all the following information is not included on the NAIC Standard A&H Transmittal Sheet):			
	a) A reference "Re:" line with the insurance company's name and NAIC number, and the form number of **each** form to be filed.			
	b) If there are numerous forms in one filing, please list them on a separate sheet of paper and indicate in the reference line "see attached list." Please list the most important form first and keep the same order in related correspondence			
	c) The name of a contact person, w/ e-mail address, telephone and fax numbers. **All correspondence will be done via e-mail when possible.** On all e-mails and other correspondence, please include NAIC number, Company Name and lead form number. Any submission of additional forms or materials should include a separate response letter, for each filing being addressed.			
	d) The nature of the insurance product (e.g. Medicare Supplement, individual, small group, association group, employer group health insurance, etc.)			
Bulletin 125	A postage-paid, self-addressed envelope of adequate size to hold the "approved" or "filed" stamped duplicate correspondence and any extra copies of forms that you wish to have returned. (There is no need to send more than one copy of the forms.)			

Bulletin 125	If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each company; list each company separately on the cover letter by NAIC #, Company Name and form #.			
Required Provisions for Blanket Policies	The following rights of insurers and insureds must be disclosed in blanket accident and sickness policies issued in Indiana. Exact wording is not required, as long as the substance matches the statutory language, or is more favorable to the insured or policyholder.			
IC 27-8-5-15(b)(1)	A provision that the policy, including endorsements and a copy of the application, if any, of the policyholder and the persons insured shall constitute the entire contract between the parties, and that any statement made by the policyholder or by a person insured shall in absence of fraud, be deemed a misrepresentation and not a warranty, and that no such statements shall be used in defense to a claim under the policy, unless contained in a written application. Such person, his beneficiary, or assignee, shall have the right to make written request to the insurer for a copy of such application and the insurer shall, within fifteen (15) days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action based upon or involving any statements contained therein.			
IC 27-8-5-15(b(2)	A provision that written notice of sickness or of injury must be given to the insurer within twenty (20) days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it is shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.			
IC 27-8-5-15(b)(3)	A provision that the insurer will furnish either to the claimant or to the policyholder for delivery to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of fifteen (15) days after giving of such notice, the claimant shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting, within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.			
IC 27-8-5-15(b)(4)	A provision that in the case of claim for loss of time for disability, written proof of such loss must be furnished to the insurer within ninety (90) days after the commencement of the period for which the insurer is liable and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require, and that in the case of claim for any other loss, written proof of such loss must be furnished to the insurer within ninety (90) days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.			
IC 27-8-5-15(b)(5)	A provision that all benefits payable under the policy other than benefits for loss of time will be payable: (A) immediately upon receipt of due written proof of such loss; or (B) in accordance with IC 27-8-5.7; whichever is more favorable to the policyholder, and that, subject to due proof of loss, all accrued benefits payable under the policy for loss of time will be paid not less frequently than monthly during the continuance of the period for which the insurer is liable, and that any balance remaining unpaid at the termination of such period will be paid immediately upon receipt of such proof.			

IC 27-8-5-15(b)(6)	A provision that the insurer at its own expense, shall have the right and opportunity to examine the person of the injured or sick individual when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy where it is not prohibited by law.			
IC 27-8-5-15(b)(7)	A provision that no action at law or in equity shall be brought to recover under the policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of the policy and that no such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.			
IC 27-8-5.7	An insurer shall pay or deny each clean claim as follows: (1) If the claim is filed electronically, within thirty (30) days after the date the claim is received by the insurer. (2) If the claim is filed on paper, within forty-five (45) days after the date the claim is received by the insurer. If an insurer fails to pay or deny a clean claim in the time required under subsection (a); and the insurer subsequently pays the claim; the insurer shall pay the provider that submitted the claim interest on the accident and sickness insurance policy allowable amount of the claim paid under this section.			
IC 27-8-28 and IC 27-8-29, Bulletin 128	Grievance and appeals procedures: Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.			
Blanket Policies *must provide:*				
IC 27-8-5-21	Adopted children			
760 IAC 1-39-7	AIDS, HIV and related conditions IF other diseases covered (can't be unique exclusion)			
IC 27-8-5-26	Breast reconstruction & prosthesis IF mastectomy is covered			
IC 27-8-14.8	Colorectal cancer screening *			
IC 27-8-5-27	Dental anesthesia/ hospitalization			
IC 27-8-14.5	Diabetes treatment, supplies & equipment			
IC 27-8-5-19(c)(17)	Handicapped children beyond the age of maturity. (w/ 120 days notice to the company)			
IC 27-8-26	Individuals w/o regard to genetic testing			
IC 27-8-24-4	Infant screening tests required by IC 16-41-17-2			
IC 27-8-24.1	Inherited metabolic disease			
IC 27-8-14	Mammography* (Baseline, then 1 per year after 40 unless high risk)			
IC 27-8-24	Minimum maternity stays, IF maternity benefits offered			
IC 27-8-5.6-2(b)	Newborns, unless pregnancy pre-existed issuance of policy			
IC 27-8-20	Off-label use of certain drugs, IF drugs are covered			
IC 27-8-14.2-4	Pervasive development disorders including Autism and Asperger's			
IC 27-8-5-19(c)(5), IC 27-8-5-2.5	Pre-existing conditions			
IC 27-8-5-19(c)(18)	Insurer must recognize previous creditable coverage (w/ no exclusion for pre-existing conditions). Coverage is guaranteed renewable (unless non-payment of premiums, etc.) as per HIPAA.			
IC 27-8-14.7	Prostate cancer screening * (1 per year after 50 unless high risk)			
IC 27-8-24.3	Victims of abuse w/o regard to the abuse			
COBRA/ERISA	Opportunity for COBRA coverage if employer has 20 or more employees			
IC 27-8-5-15.6(e)	Substance Abuse Parity—when abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits.			
Blanket Policies *must offer*				
IC 27-8-14.1	Coverage for Surgical Treatment of Morbid Obesity			
See citations above	All coverage marked with a single asterisk must be offered to non-employer-based groups			
Optional Provisions for Blanket Policies				
760 IAC 1-38.1	Coordination of Benefits – Required language if included			

General Regulatory Issues	Under the authority provided by IC 27-4-1-4 the Department monitors various issues that have been determined to be unfair, misleading or potentially constitute unfair trade practices. The following issues will also be reviewed.			
Application questions 27-8-5-1(d)(2) 27-8-5-1.5(l)	1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted. 3. Small employer applications may not require applicants declining coverage to complete health questions.			
Arbitration 27-8-5-1(d)(2)	Mandatory and/or binding arbitration provisions are prohibited.			
First manifest language 27-8-5-19(c)(6) 27-8-5-2.5 27-8-15-27	Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.			
Foreign language forms Bulletin 106	Foreign language forms must comply with Bulletin 106.			
Large endorsements 27-8-5-1(d)(2) 27-8-5-1.5(l)	The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.			
Open endorsements 27-8-5-1(d)(2) 27-8-5-1.5(l)	Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.			
Privacy of health information 27-8-5-1(d)(2) 27-8-5-1.5(l)	Employers cannot be asked to reveal or certify the accuracy of any knowledge they may have regarding an individual's health condition.			
Various fees 27-8-5-1(d)(2) 27-8-5-1.5(l)	Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.			
Bulletin 103	No full and final discretion clauses except where policy is governed by ERISA			
760 IAC 1-8	Use of terms "Noncancellable" and "Guaranteed Renewable" must not be misleading			
27-8-5-1(d)(2) 27-8-5-1.5(l)	The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.			

I hereby certify, pursuant to IC 27-8-5-1.5(i)(1)(C), that the policy form submitted with this checklist meets all requirements of Indiana law.

Filer: _____

Printed: _____

Company: _____

Title: _____

Date: _____